**State of Tennessee**
**Health Services and Development Agency**
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
**www.tn.gov/hsda** Phone: 615-741-2364 Fax: 615-741-9884

# CERTIFICATE OF NEED APPLICATION

## SECTION A: APPLICANT PROFILE

### IDENTIFYING INFORMATION

***1. Name of Facility, Agency, or Institution***

_____
Name

_____ _____
Street or Route County

_____ _____ _____
City State Zip Code

Website address: _____

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

***2. Contact Person Available for Responses to Questions***

_____ _____
Name Title

_____ _____
Company Name Email address

_____ _____ _____ _____
Street or Route City State Zip Code

_____ _____
Association with Owner Phone Number

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable)*. ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

## 3. EXECUTIVE SUMMARY

### A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;
2) Ownership structure;
3) Service area;
4) Existing similar service providers;
5) Project cost;
6) Funding;
7) Financial Feasibility including when the proposal will realize a positive financial margin; and
8) Staffing.

### B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area.

Provide a brief description of how the project meets the criteria necessary for granting a CON using the data and information points provided in Section B of the application.

1) Need;
2) Economic Feasibility;
3) Quality Standards;
4) Orderly Development of adequate and effective health care.

### C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

## 4. PROJECT DETAILS

### A. *Owner of the Facility, Agency or Institution*

_____ _____
Name Phone Number

_____ _____
Street or Route County

_____ _____ _____
City State Zip Code

### B. *Type of Ownership of Control (Check One)*

1) Sole Proprietorship _____
2) Partnership _____
3) Limited Partnership _____
4) Corporation (For Profit) _____
5) Corporation (Not-for-Profit) _____
6) Government (State of TN or Political Subdivision) _____
7) Joint Venture _____
8) Limited Liability Company _____
9) Other (Specify)_____ _____
_____

*Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx.* **Attachment Section A-4AB.**

***Describe*** *the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.*

### 5. *Name of Management/Operating Entity (If Applicable)*

_____
Name

_____ _____
Street or Route County

_____ _____ _____
City State Zip Code

Website address: _____

***For new facilities or existing facilities*** *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.* **Attachment Section A-5**.

**6A**. ***Legal Interest in the Site***

***(Check the appropriate line and submit the following documentation)***

***The legal interest described below must be valid on the date of the Agency consideration of the certificate of need application.***

- ☐ **Ownership** (Applicant or applicant's parent company/owner)
  Submit a copy of the title/deed.

- ☐ **Lease** (Applicant or applicant's parent company/owner)
  Attach a fully executed lease that includes the terms of the lease and the actual lease expense.

- ☐ **Option to Purchase**
  Attach a fully executed Option that includes the anticipated purchase price

- ☐ **Option to Lease**
  Attach a fully executed Option that includes the anticipated terms of the Option and anticipated lease expense

- ☐ **Other** (Specify)

***Check appropriate line above:*** *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

**Attachment Section A-6A**

**6B.** Briefly describe the following and attach the requested documentation on an 8 ½" x 11" sheet of white paper, legibly labeling all requested information.

1) Plot Plan **must include**:
   a) Size of site (***in acres***);
   b) Location of structure on the site;
   c) Location of the proposed construction/renovation; and
   d) Names of streets, roads or highway that cross or border the site.

2) Floor Plan – If the facility has multiple floors, submit one page per floor. If more than one page is needed, label each page.

a) Patient care rooms (private or semi-private)
b) Ancillary areas
c) Equipment areas
d) Other (specify)

3) Public Transportation Route - Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

**Attachment Section A-6B-1 a-d, 6B-2, 6B-3.**

**7**. ***Type of Institution*** ***(Check as appropriate--more than one response may apply)***

| | | | | | |
|---|---|---|---|---|---|
| A. | Hospital (Specify)_____ | _____ | H | Nursing Home | _____ |
| B. | Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty | _____ | I. | Outpatient Diagnostic Center | _____ |
| | | | J. | Rehabilitation Facility | _____ |
| C. | ASTC, Single Specialty | _____ | K. | Residential Hospice | _____ |
| D. | Home Health Agency | _____ | L. | Nonresidential Substitution-Based Treatment Center for Opiate Addiction | _____ |
| E. | Hospice | _____ | | | |
| F. | Mental Health Hospital | _____ | | | |
| G. | Intellectual Disability Institutional Habilitation Facility ICF/IID | _____ | M. | Other (Specify)_____ _____ | _____ |

**8.** **Purpose of Review** ***(Check appropriate lines(s) – more than one response may apply)***

| | | | | | |
|---|---|---|---|---|---|
| A. | Establish New Health Care Institution | _____ | G. | MRI Unit Increase | _____ |
| B. | Change in Bed Complement | _____ | H. | Satellite Emergency Department | _____ |
| C. | Initiation of Health Care Service as Defined in TCA 68-11-1607(4) (Specify) _____ | _____ | I. | Addition of ASTC Specialty | _____ |
| | | | J. | Addition of Therapeutic Catheterization | _____ |
| D. | Relocation and/or Replacement | _____ | K. | Other (Specify)_____ _____ | _____ |
| E. | Initiation of MRI | _____ | | | |
| F. | Initiation of Pediatric MRI | _____ | | | |

**9.** **Medicaid/TennCare, Medicare Participation**

MCO Contracts [Check all that apply]

___AmeriGroup ___United Healthcare Community Plan ___BlueCare ___TennCare Select

*Medicare Provider Number* _____

*Medicaid Provider Number* _____

*Certification Type* _____

**If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?**

**Medicare __Yes __No __N/A Medicaid/TennCare __Yes __No __N/A**

**10. Bed Complement Data**

**A. Please indicate current and proposed distribution and certification of facility beds.**

| | | *Current Licensed* | *Beds Staffed* | *Beds Proposed* | **Beds Approved* | ***Beds Exempted* | *TOTAL Beds at Completion* |
|---|---|---|---|---|---|---|---|
| 1) | Medical | | | | | | |
| 2) | Surgical | | | | | | |
| 3) | ICU/CCU | | | | | | |
| 4) | Obstetrical | | | | | | |
| 5) | NICU | | | | | | |
| 6) | Pediatric | | | | | | |
| 7) | Adult Psychiatric | | | | | | |
| 8) | Geriatric Psychiatric | | | | | | |
| 9) | Child/Adolescent Psychiatric | | | | | | |
| 10) | Rehabilitation | | | | | | |
| 11) | Adult Chemical Dependency | | | | | | |
| 12) | Child/Adolescent Chemical Dependency | | | | | | |
| 13) | Long-Term Care Hospital | | | | | | |
| 14) | Swing Beds | | | | | | |
| 15) | Nursing Home – SNF (Medicare only) | | | | | | |
| 16) | Nursing Home – NF (Medicaid only) | | | | | | |
| 17) | Nursing Home – SNF/NF (dually certified Medicare/Medicaid) | | | | | | |
| 18) | Nursing Home – Licensed (non-certified) | | | | | | |
| 19) | ICF/IID | | | | | | |
| 20) | Residential Hospice | | | | | | |
| **TOTAL** | | | | | | | |

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

**B.** Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services.

**C.** Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

| CON Number(s) | CON Expiration Date | Total Licensed Beds Approved |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**11. Home Care Organizations –** Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

| | Existing Licensed County | Parent Office County | Proposed Licensed County | | Existing Licensed County | Parent Office County | Proposed Licensed County |
|---|---|---|---|---|---|---|---|
| Anderson | ☐ | ☐ | ☐ | Lauderdale | ☐ | ☐ | ☐ |
| Bedford | ☐ | ☐ | ☐ | Lawrence | ☐ | ☐ | ☐ |
| Benton | ☐ | ☐ | ☐ | Lewis | ☐ | ☐ | ☐ |
| Bledsoe | ☐ | ☐ | ☐ | Lincoln | ☐ | ☐ | ☐ |
| Blount | ☐ | ☐ | ☐ | Loudon | ☐ | ☐ | ☐ |
| Bradley | ☐ | ☐ | ☐ | McMinn | ☐ | ☐ | ☐ |
| Campbell | ☐ | ☐ | ☐ | McNairy | ☐ | ☐ | ☐ |
| Cannon | ☐ | ☐ | ☐ | Macon | ☐ | ☐ | ☐ |
| Carroll | ☐ | ☐ | ☐ | Madison | ☐ | ☐ | ☐ |
| Carter | ☐ | ☐ | ☐ | Marion | ☐ | ☐ | ☐ |
| Cheatham | ☐ | ☐ | ☐ | Marshall | ☐ | ☐ | ☐ |
| Chester | ☐ | ☐ | ☐ | Maury | ☐ | ☐ | ☐ |
| Claiborne | ☐ | ☐ | ☐ | Meigs | ☐ | ☐ | ☐ |
| Clay | ☐ | ☐ | ☐ | Monroe | ☐ | ☐ | ☐ |
| Cocke | ☐ | ☐ | ☐ | Montgomery | ☐ | ☐ | ☐ |
| Coffee | ☐ | ☐ | ☐ | Moore | ☐ | ☐ | ☐ |
| Crockett | ☐ | ☐ | ☐ | Morgan | ☐ | ☐ | ☐ |
| Cumberland | ☐ | ☐ | ☐ | Obion | ☐ | ☐ | ☐ |
| Davidson | ☐ | ☐ | ☐ | Overton | ☐ | ☐ | ☐ |
| Decatur | ☐ | ☐ | ☐ | Perry | ☐ | ☐ | ☐ |
| DeKalb | ☐ | ☐ | ☐ | Pickett | ☐ | ☐ | ☐ |
| Dickson | ☐ | ☐ | ☐ | Polk | ☐ | ☐ | ☐ |
| Dyer | ☐ | ☐ | ☐ | Putnam | ☐ | ☐ | ☐ |
| Fayette | ☐ | ☐ | ☐ | Rhea | ☐ | ☐ | ☐ |
| Fentress | ☐ | ☐ | ☐ | Roane | ☐ | ☐ | ☐ |
| Franklin | ☐ | ☐ | ☐ | Robertson | ☐ | ☐ | ☐ |
| Gibson | ☐ | ☐ | ☐ | Rutherford | ☐ | ☐ | ☐ |
| Giles | ☐ | ☐ | ☐ | Scott | ☐ | ☐ | ☐ |
| Grainger | ☐ | ☐ | ☐ | Sequatchie | ☐ | ☐ | ☐ |
| Greene | ☐ | ☐ | ☐ | Sevier | ☐ | ☐ | ☐ |
| Grundy | ☐ | ☐ | ☐ | Shelby | ☐ | ☐ | ☐ |
| Hamblen | ☐ | ☐ | ☐ | Smith | ☐ | ☐ | ☐ |
| Hamilton | ☐ | ☐ | ☐ | Stewart | ☐ | ☐ | ☐ |
| Hancock | ☐ | ☐ | ☐ | Sullivan | ☐ | ☐ | ☐ |
| Hardeman | ☐ | ☐ | ☐ | Sumner | ☐ | ☐ | ☐ |
| Hardin | ☐ | ☐ | ☐ | Tipton | ☐ | ☐ | ☐ |
| Hawkins | ☐ | ☐ | ☐ | Trousdale | ☐ | ☐ | ☐ |
| Haywood | ☐ | ☐ | ☐ | Unicoi | ☐ | ☐ | ☐ |
| Henderson | ☐ | ☐ | ☐ | Union | ☐ | ☐ | ☐ |
| Henry | ☐ | ☐ | ☐ | Van Buren | ☐ | ☐ | ☐ |
| Hickman | ☐ | ☐ | ☐ | Warren | ☐ | ☐ | ☐ |
| Houston | ☐ | ☐ | ☐ | Washington | ☐ | ☐ | ☐ |
| Humphreys | ☐ | ☐ | ☐ | Wayne | ☐ | ☐ | ☐ |
| Jackson | ☐ | ☐ | ☐ | Weakley | ☐ | ☐ | ☐ |
| Jefferson | ☐ | ☐ | ☐ | White | ☐ | ☐ | ☐ |
| Johnson | ☐ | ☐ | ☐ | Williamson | ☐ | ☐ | ☐ |
| Knox | ☐ | ☐ | ☐ | Wilson | ☐ | ☐ | ☐ |
| Lake | ☐ | ☐ | ☐ | | | | |

## 12. Square Footage and Cost Per Square Footage Chart

| Unit/Department | Existing Location | Existing SF | Temporary Location | Proposed Final Location | Proposed Final Square Footage | | |
|---|---|---|---|---|---|---|---|
| | | | | | Renovated | New | Total |
| | | | | | | | |
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| | | | | | | | |
| Unit/Department GSF Sub-Total | | | | | | | |
| Other GSF Total | | | | | | | |
| Total GSF | | | | | | | |
| *Total Cost | | | | | | | |
| **Cost Per Square Foot | | | | | | | |
| Cost per Square Foot Is Within Which Range<br>*(For quartile ranges, please refer to the Applicant's Toolbox on [www.tn.gov/hsda](www.tn.gov/hsda))* | | | | | ☐ Below 1st Quartile<br>☐ Between 1st and 2nd Quartile<br>☐ Between 2nd and 3rd Quartile<br>☐ Above 3rd Quartile | ☐ Below 1st Quartile<br>☐ Between 1st and 2nd Quartile<br>☐ Between 2nd and 3rd Quartile<br>☐ Above 3rd Quartile | ☐ Below 1st Quartile<br>☐ Between 1st and 2nd Quartile<br>☐ Between 2nd and 3rd Quartile<br>☐ Above 3rd Quartile |

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

**A**. Describe the construction and renovation associated with the proposed project. If applicable, provide a description of the existing building, including age of the building and the use of space vacated due to the proposed project.

**13. MRI, PET, and/or Linear Accelerator**

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or
2. Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

**A.** Complete the chart below for acquired equipment.

| | | |
|---|---|---|
| ☐ Linear Accelerator | Mev _____ Types: □ SRS □ IMRT □ IGRT □ Other _____<br>Total Cost*: _____ □ By Purchase □ By Lease Expected Useful Life (yrs) ___<br>□ New □ Refurbished □ If not new, how old? (yrs) _____ |
| ☐ MRI | Tesla: ____ Magnet: □ Breast □ Extremity □ Open □ Short Bore □ Other _____<br>Total Cost*: _____ □ By Purchase □ By Lease Expected Useful Life (yrs) ___<br>□ New □ Refurbished □ If not new, how old? (yrs) _____ |
| ☐ PET | □ PET only □ PET/CT □ PET/MRI<br>Total Cost*: _____ □ By Purchase □ By Lease Expected Useful Life (yrs) ___<br>□ New □ Refurbished □ If not new, how old? (yrs) _____ |

* As defined by Agency Rule 0720-9-.01(4)(b)

**B**. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

**C.** Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

**D.** Schedule of Operations:

| Location | Days of Operation (*Sunday through Saturday*) | Hours of Operation (*example: 8 am – 3 pm*) |
|---|---|---|
| Fixed Site *(Applicant)* | | |
| Mobile Locations *(Applicant)* | | |
| *(Name of Other Location)* | | |
| *(Name of Other Location)* | | |

**E**. Identify the clinical applications to be provided that apply to the project.

**F**. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

## SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." In making determinations, the Agency uses as guidelines the goals, objectives, criteria, and standards provided in the State Health Plan.
Additional criteria for review are prescribed in Chapter 11 of the Agency's Rules, Tennessee Rules and Regulations 01730-11.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate.

## QUESTIONS

### NEED

**The responses to this section of the application will help determine whether the project will provide needed health care facilities or services in the area to be served.**

**1.** Provide a response to the applicable criteria and standards for the type of institution or service requested. https://www.tn.gov/hsda/hsda-criteria-and-standards.html

**2.** Describe how this project relates to existing facilities or services operated by the applicant including previously approved Certificate of Need projects and future long-range development plans.

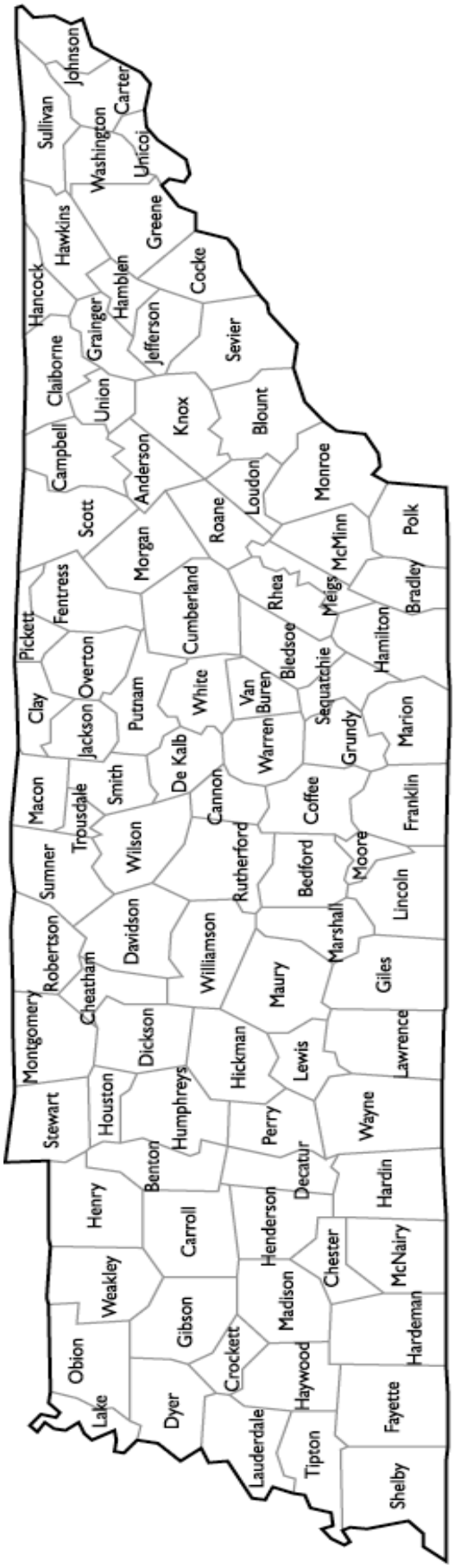
**3.** Identify the proposed service area and provide justification for its reasonableness. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked and shaded to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. **Attachment Section B - Need-3.**

Complete the following utilization tables for each county in the service area, if applicable:

| **Service Area Counties** | **Historical Utilization-County Residents – Most Recent Year (YEAR = _____)** | **% of total ☐ procedures ☐ cases ☐ patients ☐Other _____.** |
|---|---|---|
| County #1 | | |
| County #2 | | |
| County #3 | | |
| County #4 | | |
| Etc. | | |
| Total | | 100% |

| **Service Area Counties** | **Projected Utilization-County Residents-Year 1 (YEAR = _____)** | **% of total ☐ procedures ☐ cases ☐ patients ☐Other _____.** |
|---|---|---|
| County #1 | | |
| County #2 | | |
| County #3 | | |
| County #4 | | |
| Etc. | | |
| Total | | 100% |

**County Level Map**



**4. A**. 1) Describe the demographics of the population to be served by the proposal.

2) Provide the following data for each county in the service area using current and projected population data from the Department of Health (https://www.tn.gov/content/tn/health/health-program-areas/statistics/health-data/con.html ), the most recent enrollee data from the Division of TennCare (https://www.tn.gov/tenncare/information-statistics/enrollment-data.html ), and US Census Bureau demographic information (: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml ),.

TennCare Enrollment Data: https://www.tn.gov/tenncare/information-statistics/enrollment-data.html

Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

| Demographic Variable/Geographic Area | Department of Health/Health Statistics | | | | | | | Census Bureau | | | | TennCare | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total Population-Current Year ___ | Total Population-Projected Year ___ | Total Population-% Change | *Target Population-___Current Year ___ | Target Population-Project Year ___ | Target Population-% Change | Target Population Projected Year as % of Total | Median Age | Median Household Income | Person Below Poverty Level | Person Below Poverty Level as % of Total | TennCare Enrollees | TennCare Enrollees as % of Total |
| County A | | | | | | | | | | | | | |
| County B, etc. | | | | | | | | | | | | | |
| Service Area Total | | | | | | | | | | | | | |
| State of TN Total | | | | | | | | | | | | | |

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-17. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2019, then default Projected Year is 2023.*

***Be sure to identify the target population, e.g., Age 65+, the current year and projected year being used.***

**B.** Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, TennCare or Medicaid recipients, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

**5.** Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

**6.** Provide applicable utilization and/or occupancy statistics for your institution services for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

## ECONOMIC FEASIBILITY

**The responses to this section of the application will help determine whether the project can be economically accomplished and maintained.**

**1.** Project Cost Chart Instructions

**A.** All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee) (See Application Instructions for Filing Fee)

**B.** The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or “per click” arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

**C.** The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

**D.** The Total Construction Cost reported on line 5 should equal the Total Cost reported on the Square Footage Chart.

**E.** For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

1) A general description of the project;
2) An estimate of the cost to construct the project;
3) A description of the status of the site’s suitability for the proposed project; and
4) Attesting the physical environment will conform to applicable federal standards, manufacturer’s specifications and licensing agencies’ requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities or comparable document in current use by the licensing authority.

## PROJECT COST CHART

A. Construction and equipment acquired by purchase:

1. Architectural and Engineering Fees _____
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees _____
3. Acquisition of Site _____
4. Preparation of Site _____
5. Total Construction Costs _____
6. Contingency Fund _____
7. Fixed Equipment (Not included in Construction Contract) _____
8. Moveable Equipment (List all equipment over $50,000 as separate attachments) _____
9. Other (Specify) _____ _____

B. Acquisition by gift, donation, or lease:

1. Facility (inclusive of building and land) _____
2. Building only _____
3. Land only _____
4. Equipment (Specify)_____ _____
5. Other (Specify) _____ _____

C. Financing Costs and Fees:

1. Interim Financing _____
2. Underwriting Costs _____
3. Reserve for One Year's Debt Service _____
4. Other (Specify) _____ _____

D. Estimated Project Cost (A+B+C) _____

E. CON Filing Fee _____

F. Total Estimated Project Cost (D+E) **TOTAL** _____

**2.** Identify the funding source(s) for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment Section B-Economic Feasibility-2.)***

__ A. Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ B. Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ C. General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

__ D. Grants – Notification of intent form for grant application or notice of grant award;

__ E. Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

__ F. Other – Identify and document funding from all other sources.

**3.** Complete Historical Data Charts on the following two pages—***Do not modify the Charts provided or submit Chart substitutions!***

Historical Data Chart(s) provide revenue and expense information for the last *three (3)* years for which complete data is available. The "Project Only Chart" provides information for the services being presented in the proposed project while the "Total Facility Chart" provides information for the entire facility. Complete both, if applicable.

*Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.*

□ Project Only
□ Total Facility

**HISTORICAL DATA CHART**

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

| | | Year_____ | Year_____ | Year_____ |
|---|---|---|---|---|
| A. | Utilization Data | | | |
| | Specify Unit of Measure _____ | _____ | _____ | _____ |
| B. | Revenue from Services to Patients | | | |
| | 1. Inpatient Services | $_____ | $_____ | $_____ |
| | 2. Outpatient Services | _____ | _____ | _____ |
| | 3. Emergency Services | _____ | _____ | _____ |
| | 4. Other Operating Revenue (Specify)_____ | _____ | _____ | _____ |
| | **Gross Operating Revenue** | $_____ | $_____ | $_____ |
| C. | Deductions from Gross Operating Revenue | | | |
| | 1. Contractual Adjustments | $_____ | $_____ | $_____ |
| | 2. Provision for Charity Care | _____ | _____ | _____ |
| | 3. Provisions for Bad Debt | _____ | _____ | _____ |
| | **Total Deductions** | $_____ | $_____ | $_____ |
| **NET OPERATING REVENUE** | | $_____ | $_____ | $_____ |
| D. | Operating Expenses | | | |
| | 1. Salaries and Wages | | | |
| | a. Direct Patient Care | _____ | _____ | _____ |
| | b. Non-Patient Care | _____ | _____ | _____ |
| | 2. Physician's Salaries and Wages | _____ | _____ | _____ |
| | 3. Supplies | _____ | _____ | _____ |
| | 4. Rent | | | |
| | a. Paid to Affiliates | _____ | _____ | _____ |
| | b. Paid to Non-Affiliates | _____ | _____ | _____ |
| | 5. Management Fees: | | | |
| | a. Paid to Affiliates | _____ | _____ | _____ |
| | b. Paid to Non-Affiliates | _____ | _____ | _____ |
| | 6. Other Operating Expenses (D6) | _____ | _____ | _____ |
| | **Total Operating Expenses** | $_____ | $_____ | $_____ |
| E. | **Earnings Before Interest, Taxes and Depreciation** | $_____ | $_____ | $_____ |
| F. | Non-Operating Expenses | | | |
| | 1. Taxes | $_____ | $_____ | $_____ |
| | 2. Depreciation | _____ | _____ | _____ |
| | 3. Interest | _____ | _____ | _____ |
| | 4. Other Non-Operating Expenses | _____ | _____ | _____ |
| | **Total Non-Operating Expenses** | $_____ | $_____ | $_____ |
| **NET INCOME (LOSS)** | | $_____ | $_____ | $_____ |

*Chart Continues Onto Next Page*

| | | | |
|---|---|---|---|
| **NET INCOME (LOSS)** | $_____ | $_____ | $_____ |
| G. Other Deductions | | | |
| 1. Annual Principal Debt Repayment | $_____ | $_____ | $_____ |
| 2. Annual Capital Expenditure | _____ | _____ | _____ |
| **Total Other Deductions** | $_____ | $_____ | $_____ |
| **NET BALANCE** | $_____ | $_____ | $_____ |
| **DEPRECIATION** | $_____ | $_____ | $_____ |
| **FREE CASH FLOW (Net Balance + Depreciation)** | $_____ | $_____ | $_____ |

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☐ Project Facility

☐ Total Only

## HISTORICAL DATA CHART-OTHER EXPENSES

| **OTHER OPERATING EXPENSES CATEGORIES (D6)** | **Year**____ | **Year**___ | ***Year***_____ |
|---|---|---|---|
| 1. Professional Services Contract | $_____ | $_____ | $_____ |
| 2. Contract Labor | _____ | _____ | _____ |
| 3. Imaging Interpretation Fees | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ |
| 6. _____ | _____ | _____ | _____ |
| 7. _____ | _____ | _____ | _____ |
| ***Total Other Expenses** | **$**_____ | **$**_____ | **$**_____ |

**Total other expenses should equal Line D.6. In the Historical Data Chart*

**4.** Complete Projected Data Charts on the following two pages – ***Do not modify the Charts provided or submit Chart substitutions!***

Projected Data Chart(s) provide information for the two years following the completion of the project. The "Project Only Chart" should reflect revenue and expense projections for the project (*i.e*., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The "Total Facility Chart" should reflect information for the total facility. Complete both, if applicable.

*Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.*

□ Project Only
□ Total Facility

**PROJECTED DATA CHART**

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in _____ (Month).

| | | **Year**_____ | **Year**_____ |
|---|---|---|---|
| A. | Utilization Data | | |
| | Specify Unit of Measure _____ | _____ | _____ |
| B. | Revenue from Services to Patients | | |
| | 1. Inpatient Services | $_____ | $_____ |
| | 2. Outpatient Services | _____ | _____ |
| | 3. Emergency Services | _____ | _____ |
| | 4. Other Operating Revenue (Specify)_____ | _____ | _____ |
| | **Gross Operating Revenue** | **$**_____ | **$**_____ |
| C | Deductions from Gross Operating Revenue | | |
| . | | | |
| | 1. Contractual Adjustments | $_____ | $_____ |
| | 2. Provision for Charity Care | _____ | _____ |
| | 3. Provisions for Bad Debt | _____ | _____ |
| | **Total Deductions** | $_____ | $_____ |
| **NET OPERATING REVENUE** | | $_____ | $_____ |
| D. | Operating Expenses | | |
| | 1. Salaries and Wages | _____ | _____ |
| | a. Direct Patient Care | _____ | _____ |
| | b. Non-Patient Care | _____ | _____ |
| | 2. Physician's Salaries and Wages | _____ | _____ |
| | 3. Supplies | _____ | _____ |
| | 4. Rent | | |
| | a. Paid to Affiliates | _____ | _____ |
| | b. Paid to Non-Affiliates | _____ | _____ |
| | 5. Management Fees: | | |
| | a. Paid to Affiliates | _____ | _____ |
| | b. Paid to Non-Affiliates | _____ | _____ |
| | 6. Other Operating Expenses (D6) | _____ | _____ |
| | **Total Operating Expenses** | $_____ | $_____ |
| E. | **Earnings Before Interest, Taxes and Depreciation** | $_____ | $_____ |
| F. | Non-Operating Expenses | | |
| | 1. Taxes | $_____ | $_____ |
| | 2. Depreciation | _____ | _____ |
| | 3. Interest | _____ | _____ |
| | 4. Other Non-Operating Expenses | _____ | _____ |
| | **Total Non-Operating Expenses** | $_____ | $_____ |
| **NET INCOME (LOSS)** | | $_____ | $_____ |

*Chart Continues Onto Next Page*

| | | | |
|---|---|---|---|
| **NET INCOME (LOSS)** | | $_____ | $_____ |
| G. | Other Deductions | | |
| 1. | Estimated Annual Principal Debt Repayment | $_____ | $_____ |
| 2. | Annual Capital Expenditure | _____ | _____ |
| | **Total Other Deductions** | $_____ | $_____ |
| | **NET BALANCE** | $_____ | $_____ |
| | **DEPRECIATION** | $_____ | $_____ |
| | **FREE CASH FLOW (Net Balance + Depreciation)** | $_____ | $_____ |

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☐ Project Facility

☐ Total Only

## PROJECTED DATA CHART-OTHER EXPENSES

| **OTHER OPERATING EXPENSES CATEGORIES (D6)** | | **Year_____** | **Year_____** |
|---|---|---|---|
| 1. | Professional Services Contract | $_____ | $_____ |
| 2. | Contract Labor | _____ | _____ |
| 3. | Imaging Interpretation Fees | _____ | _____ |
| 4. | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ |
| 7. | _____ | _____ | _____ |
| | ***Total Other Expenses** | **$_____** | **$_____** |

**Total other expenses should equal Line D.6. In the Projected Data Chart*

**5. A**. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Charts for Year 1 and Year 2 of the proposed project. Complete Project Only Chart and Total Facility Chart, if applicable.

**Project Only Chart**

| | Previous Year to Most Recent Year Year ____ | Most Recent Year Year____ | Year One Year___ | Year Two Year_____ | % Change (Current Year to Year 2) |
|---|---|---|---|---|---|
| **Gross Charge** *(Gross Operating Revenue/Utilization Data)* | | | | | |
| **Deduction from Revenue** *(Total Deductions/Utilization Data)* | | | | | |
| **Average Net Charge** *(Net Operating Revenue/Utilization Data)* | | | | | |

**Total Facility Chart**

| | Previous Year to Most Recent Year Year ____ | Most Recent Year Year____ | Year One Year___ | Year Two Year_____ | % Change (Current Year to Year 2) |
|---|---|---|---|---|---|
| **Gross Charge** *(Gross Operating Revenue/Utilization Data)* | | | | | |
| **Deduction from Revenue** *(Total Deductions/Utilization Data)* | | | | | |
| **Average Net Charge** *(Net Operating Revenue/Utilization Data)* | | | | | |

**B.** Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

**C.** Compare the proposed charges to those of similar facilities/services in the service area/adjoining service areas, or to proposed charges of recently approved Certificates of Need. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

**6. A**. Discuss how projected utilization rates will be sufficient to support financial performance.

1) Noting when the project's financial breakeven is expected, and

2) Demonstrating the availability of sufficient cash flow until financial viability is achieved.

Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as **Attachment Section B-Economic Feasibility-6A**

**B.** Net Operating Margin Ratio: The Net Operating Margin Radio demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following tables. Complete Project Only Chart and Total Facility Chart, if applicable.

**Project Only Chart**

| Year | 2nd Previous Year to Most Recent Year Year _____ | 1st Previous Year to Most Recent Year Year_____ | Most Recent Year Year_____ | Projected Year 1 Year_____ | Projected Year 2 Year _____ |
|---|---|---|---|---|---|
| Net Operating Margin Ratio | | | | | |

**Total Facility Chart**

| Year | 2nd Previous Year to Most Recent Year Year _____ | 1st Previous Year to Most Recent Year Year_____ | Most Recent Year Year_____ | Projected Year 1 Year_____ | Projected Year 2 Year _____ |
|---|---|---|---|---|---|
| Net Operating Margin Ratio | | | | | |

**C.** Capitalization Ratio: The Long-term debt to capitalization ratio measures the proportion of debt financing in a business's permanent (long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: ((Long-Term Debt)/Long-Term Debt + Total Equity {Net Assets}) X 100.

For self or parent company funded projects, provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. Capitalization Ratios are not expected from outside the company lenders that provide funding. **This question is applicable to all applications regardless of whether or not the project is being partially or totally funded by debt financing.**

**7.** Discuss the project's participation in state and federal revenue programs, including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below. Complete Project Only Chart and Total Facility Chart, if applicable.

Applicant's Projected Payor Mix, Year 1
Project Only Chart

| Payor Source | Projected Gross Operating Revenue | As a % of total |
|---|---|---|
| Medicare/Medicare Managed Care | | |
| TennCare/Medicaid | | |
| Commercial/Other Managed Care | | |
| Self-Pay | | |
| Other (Specify)_____ | | |
| Total* | | |
| Charity Care | | |

**Needs to match Gross Operating Revenue Year One on Projected Data Chart*

Applicant's Projected Payor Mix, Year 1
Total Facility Chart

| Payor Source | Projected Gross Operating Revenue | As a % of total |
|---|---|---|
| Medicare/Medicare Managed Care | | |
| TennCare/Medicaid | | |
| Commercial/Other Managed Care | | |
| Self-Pay | | |
| Other (Specify)_____ | | |
| Total* | | |
| Charity Care | | |

**Needs to match Gross Operating Revenue Year One on Projected Data Chart*

**8.** Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources, such as the US Department of Labor. Wage data pertaining to healthcare professions can be found at the following link: https://www.bls.gov/oes/current/oes_tn.htm.

| Position Classification | Existing FTEs (enter year) | Projected FTEs Year 1 | Average Wage (Contractual Rate) | Area Wide/Statewide Average Wage |
|---|---|---|---|---|
| **A. Direct Patient Care Positions** | | | | |
| *Position 1* | | | | |
| *Position 2* | | | | |
| *Position "etc."* | | | | |
| **Total Direct Patient Care Positions** | | | | |
| **B. Non-Patient Care Positions** | | | | |
| *Position 1* | | | | |
| *Position 2* | | | | |
| *Position "etc."* | | | | |
| **Total Non-Patient Care Positions** | | | | |
| **Total Employees** *(A+B)* | | | | |
| **C. Contractual Staff** | | | | |
| **Total Staff** *(A+B+C)* | | | | |

**9.** What alternatives to this project were considered? Discuss the advantages and disadvantages of each, including but not limited to:

**A.** The availability of less costly, more effective and/or more efficient methods of providing the benefits intended by the project. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

**B.** Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

## QUALITY STANDARDS

**1.** Per PC 1043, Acts of 2016, any receiving a CON after July 1, 2016 must report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures Please verify that annual reporting will occur.

**2.** Quality-The the proposal shall provide health care that meets appropriate quality standards. Please address each of the following questions:

**A**. Does the applicant commit to the following?

1) Maintaining the staffing comparable to the staffing chart presented in its CON application;

2) Obtaining and maintaining all applicable state licenses in good standing;

3) Obtain and maintaining TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

4) For an existing healthcare institution applying for a CON - Has it maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action should be discussed to include any of the following: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions and what measures the applicant has or will put into place to avoid similar findings in the future

5) For an existing healthcare institution applying for a CON - Has the entity been decertified within the prior three years? If yes, please explain in detail. (This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility)

**B.** Respond to all of the following and for such occurrences, identify, explain and provide documentation:

1) Has any of the following:

a. Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

b. Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

c. Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

2) Been subjected to any of the following:

a. Final Order or Judgment in a state licensure action;

b. Criminal fines in cases involving a Federal or State health care offense;

c. Civil monetary penalties in cases involving a Federal or State health care offense;

d. Administrative monetary penalties in cases involving a Federal or State health care offense;

e. Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

f. Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

g. Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

h. Is presently subject to a corporate integrity agreement.

**C.** Does the applicant plan, within 2 years of implementation of the project, to participate in self-assessment and external assessment against nationally available benchmark data to accurately assess its level of performance in relation to established standards and to implement ways to continuously improve?
Note: Existing licensed, accredited and/or certified providers are encouraged to describe their process for same.

Please complete the chart below on accreditation, certification, and licensure plans.

1) If the applicant does not plan to participate in these type of assessments, explain why since quality healthcare must be demonstrated.

| **Credential** | **Agency** | **Status (Active or Will Apply)** |
|---|---|---|
| Licensure | □ Health<br>□ Intellectual and Developmental Disabilities<br>□ Mental Health and Substance Abuse Services | |
| Certification | □ Medicare<br>□ Medicaid/TennCare<br>□ Other_____ | |
| Accreditation | | |

2) Based upon what was checked/completed in above table, will the applicant accept a condition placed on the certificate of need relating to obtaining/maintaining license, certification, and/or accreditation?

**D.** The following list of quality measures are service specific. Please indicate which standards you will be addressing in the annual Continuing Need and Quality Measure report if the project is approved.

| | |
|---|---|
| ☐ | For Ambulatory Surgical Treatment Center projects: Estimating the number of physicians by specialty expected to utilize the facility, developing criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel, and documenting the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site? |

| | |
|---|---|
| ☐ | For Cardiac Catheterization projects:<br><br>a. Documenting a plan to monitor the quality of its cardiac catheterization program, including but not limited to, program outcomes and efficiencies; and<br><br>b. Describing how the applicant will agree to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee; and<br><br>c. Describing how cardiology staff will be maintaining:<br><br>d. Adult Program: 75 cases annually averaged over the previous 5 years;<br><br>e. Pediatric Program: 50 cases annually averaged over the previous 5 years. |
| ☐ | For Open Heart projects:<br><br>f. Describing how the applicant will staff and maintain the number of who will perform the volume of cases consistent with the State Health Plan (annual average of the previous 2 years), and maintain this volume in the future;<br><br>g. Describing how at least a surgeon will be recruited and retained (at least one shall have 5 years experience);<br><br>h. Describing how the applicant will participate in a data reporting, quality improvement, outcome monitoring, and external assessment system that benchmarks outcomes based on national norms (demonstrated active participation in the STS National Database is expected and shall be considered evidence of meeting this standard). |
| ☐ | For Comprehensive Inpatient Rehabilitation Services projects: Retaining or recruiting a physiatrist? |
| ☐ | For Home Health projects: Documenting the existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system. |
| ☐ | For Hospice projects: Documenting the existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system. |
| ☐ | For Megavoltage Radiation Therapy projects: Describing or demonstrating how the staffing and quality assurance requirements will be met of the American Society of Therapeutic Radiation and Oncology (ASTRO), the American College of Radiology (ACR), the American College of Radiation Oncology (ACRO), National Cancer Institute (NCI), or a similar accrediting authority. |
| ☐ | For Neonatal Intensive Care Unit projects: Documenting the existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems; document the intention and ability to comply with the staffing guidelines and qualifications set forth by the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities; and participating in the Tennessee Initiative for Perinatal Quality Care (TIPQC). |
| ☐ | For Nursing Home projects: Documenting the existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems, including in particular details on its Quality Assurance and Performance Improvement program. |
| ☐ | For Inpatient Psychiatric projects:<br><br>• Describing or demonstrating appropriate accommodations for:<br><br>• Seclusion/restraint of patients who present management problems and children who need quiet space, proper sleeping and bathing arrangements for all patients); |

| | |
|---|---|
| | • Proper sleeping and bathing arrangements;<br>• Adequate staffing (i.e. that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all times);<br>• A staffing plan that will lead to quality care of the patient population served by the project.<br>• An existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems; and<br>• If other psychiatric facilities are owned or administered, providing information on satisfactory surveys and quality improvement programs at those facilities.<br>Involuntary admissions if identified in CON criteria and standard review |
| ☐ | For Freestanding Emergency Department projects: Demonstrating that it will be accredited with the Joint Commission or other applicable accrediting agency, subject to the same accrediting standards as the licensed hospital with which it is associated. |
| ☐ | For Organ Transplant projects: Describing how the applicant will achieve and maintain institutional membership in the national Organ Procurement and Transportation Network (OPTN), currently operating as the United Network for Organ Sharing (UNOS), within one year of program initiation. Describing how the applicant shall comply with CMS regulations set forth by 42 CFR Parts 405, 482, and 498, Medicare Program; Hospital Conditions of Participation: Requirements for Approval and Re-Approval of Transplant Centers To Perform Organ Transplants. |
| ☐ | For Relocation and/or Replacement of Health Care Institution projects: Describing how facility and/or services specific measures will be met. |

**CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE**

**The responses to this section of the application helps determine whether the project will contribute to the orderly development of healthcare within the service area.**

**1.** List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

**2.** Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

**A.** Positive Effects

**B.** Negative Effects

**3.** **A**. Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements, CMS, and/or accrediting agencies requirements, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

**B**. Document the category of license/certification that is applicable to the project and why. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

**C**. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

**4.** Outstanding Projects:

**A.** Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

**Outstanding Projects**

| CON Number | Project Name | Date Approved | *Annual Progress Report(s) | | Expiration Date |
|---|---|---|---|---|---|
| | | | Due Date | Date Filed | |
| | | | | | |
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* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

**B.** Describe the current progress, and status of each applicable outstanding CON.

**5.** Equipment Registry – For the applicant and all entities in common ownership with the applicant.

**A.** Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)? _____

**B.** If yes, have you submitted their registration to HSDA? If you have, what was the date of submission?_____

**C.** If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission? _____

## SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at https://www.tn.gov/health/health-program-areas/health-planning/state-health-plan.html) The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

1. The purpose of the State Health Plan is to improve the health of Tennesseans.

2. Every citizen should have reasonable access to health care.

3. The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system.

4. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

5. The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.

### PROOF OF PUBLICATION

**Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.**

Date LOI was Submitted: _____

Date LOI was Published: _____

## NOTIFICATION REQUIREMENTS

1. T.C.A. §68-11-1607(c)(9)(A) states that "…Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

2. T.C.A §68-11-1607(c)(9)(B) states that "… If an application involves a healthcare facility in which a county or municipality is the lessor of the facility or real property on which it sits, then within ten (10) days of filing the application, the applicant shall notify the chief executive officer of the county or municipality of the filing, by certified mail, return receipt requested."

**Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.**

Please provide documentation of these notifications.

## DEVELOPMENT SCHEDULE

**T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.**

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the CON is granted and the project cannot be completed within the standard completion time period (3 years for hospital projects and 2 years for all others), please document why an extended period should be approved and document the "good cause" for such an extension.**

# PROJECT COMPLETION FORECAST CHART

**Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.**

| **Phase** | **Days Required** | **Anticipated Date [Month/Year]** |
|---|---|---|
| 1. Initial HSDA decision date | | |
| 2. Architectural and engineering contract signed | | |
| 3. Construction documents approved by the Tennessee Department of Health | | |
| 4. Construction contract signed | | |
| 5. Building permit secured | | |
| 6. Site preparation completed | | |
| 7. Building construction commenced | | |
| 8. Construction 40% complete | | |
| 9. Construction 80% complete | | |
| 10. Construction 100% complete (approved for occupancy) | | |
| 11. *Issuance of License | | |
| 12. *Issuance of Service | | |
| 13. Final Architectural Certification of Payment | | |
| 14. Final Project Report Form submitted (Form HR0055) | | |

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

**NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date**

## AFFIDAVIT

STATE OF _____

COUNTY OF _____

_____, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

_____
SIGNATURE/TITLE

Sworn to and subscribed before me this _____ day of _____ (Month), _____ (Year) a Notary

Public in and for the County/State of _____.

_____
NOTARY PUBLIC

My commission expires _____ (Month/Day), _____ (Year).